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Medicare

1991 Highlights

Notice to
Medicare Beneficiaries
explaining

Recent
Medicare
Changes
under the
Omnibus Budget Reconciliation
Act of 1990

Including Information on:

- 1991 Medicare benefits
- Participating Physicians and Suppliers
- Limits to Medicare Coverage
- Health Insurance to Supplement Medicare
- Help for Low-Income Beneficiaries

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.S. Department of Health and Human Services
ealth Care Financing Administration

Medicare Benefits In Brief

The Medicare health insurance program provides comprehensive acute-care coverage for most people 65 and over. Medicare also serves certain younger people who are receiving Social Security or Railroad Retirement disability benefits. People of any age who have chronic kidney disease and need dialysis or kidney transplants also are eligible for benefits. Medicare currently covers over 34 million people, of whom about 3 million are disabled and some 150,000 are kidney disease patients. Medicare covered services may be provided by coordinated care plans (see page 10) or through fee-for-service arrangements. The Medicare program has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

This notice is meant to explain the Medicare program changes going into effect in 1991, but it is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

Covered Services Per Benefit Period[1]

	Medicare Pays **	You Pay **
	All but $628	$628
	All but $157 a day	$157 a day
*	All but $314 a day	$314 a day
s	Nothing	All costs
	100% of approved amount	Nothing
/	All but $78.50 a day	$78.50 a day
s	Nothing	All costs
illed aide etc.	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
r	All but limited costs for inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care
	All but first 3 pints per calendar year	For first 3 pints***

are not renewable.
e each year.
part of Medicare during the calendar year, it does not

service as an inpatient in a hospital and ends after you
l skilled care in any other facility for 60 days in a row.
custodial care in a nursing home.

What's Not Covered?

Hospital Insurance does not cover convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, private rooms (unless medically necessary), or private duty nurses. Part A also does not pay for a stay in a skilled nursing facility if the services provided are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

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Hospital Insurance (Part A)

What's Covered?

The law limits Medicare coverage to services and items that are reasonable and necessary for the diagnosis and treatment of illness or injury. They include:

- Inpatient hospital services, including room, meals, nursing care, operating room services, drugs, medical supplies, laboratory tests, therapeutic rehabilitation services, and medical social services.
- Skilled nursing facility care for continued treatment or rehabilitation following hospitalization.
- Home health care services, including part- time or intermittent nursing services, prescribed by a physician for treatment or rehabilitation of home-bound patients.
- Hospice care for the terminally ill.

What Medicare Pays

- Medicare pays all approved charges for the first 60 days of inpatient *hospital care* in a benefit period, after you pay the first $628 of approved charges. For the 61st through the 90th day, Medicare pays all approved charges except for $157 per day, which you pay. If you need more than 90 days of hospitalization in any benefit period, you can draw on your 60 lifetime reserve days. Reserve days are not renewable. Your share of the cost for each reserve day is $314.

Medicare (Part A): Hospital Insurance-Covered Services Per Benefit Period[1]

Services	Benefit	Medicare Pays **	You Pay **
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $628	$628
	61st to 90th day	All but $157 a day	$157 a day
	91st to 150th day*	All but $314 a day	$314 a day
	Beyond 150 days	Nothing	All costs
POST-HOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.[2]	First 20 days	100% of approved amount	Nothing
	21st to 100th day	All but $78.50 a day	$78.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, supplies, etc.	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
HOSPICE CARE Available to terminally ill	As long as doctor certifies need	All but limited costs for inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care
BLOOD	Blood	All but first 3 pints per calendar year	For first 3 pints***

* 60 reserve days may be used only once; days used are not renewable.
** These figures are for 1991 and are subject to change each year.
*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
(2) Medicare and most private insurance will not pay for custodial care in a nursing home.

- Medicare helps cover 100 days of inpatient, post-hospital *skilled nursing facility care* per benefit period. Medicare pays all approved charges for the first 20 days; then you pay $78.50 a day for the 21st through the 100th day.
- Medicare pays all approved charges for medically necessary home health care that is needed and provided on a "part-time" or "intermittent" basis.
- Medicare helps pay for *hospice care* for terminally ill beneficiaries who select the hospice option. There are no deductibles, but there are small coinsurance amounts for drugs and respite care.

What's Not Covered?

Hospital Insurance does not cover convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, private rooms (unless medically necessary), or private duty nurses. Part A also does not pay for a stay in a skilled nursing facility if the services provided are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

Medical Insurance (Part B)

What's Covered?

Medicare Part B Medical Insurance helps pay for physician services, outpatient hospital services (including emergency room visits), ambulatory surgery, diagnostic tests, laboratory services, and Pap smear screenings. Coverage also is provided for outpatient physical, occupational, and speech therapy services, durable medical equipment and supplies, rural health clinic services, some home health, and a variety of other health services and supplies.

What Medicare Pays

- Medicare pays 80 percent of all approved charges for most services covered by Part B. (See the reference chart and *The Medicare Handbook* for a more complete list.) You are responsible for paying a $100 deductible for the year and the remaining 20 percent of the Medicare approved amount. You are also responsible for any charges in excess of the Medicare approved amount.

What's Not Covered?

Medical Insurance does not cover routine physical examinations, most preventive care, services not related to treatment of illness or injury, and outpatient prescription drugs to be self-administered. Coverage also is not provided for dental care or dentures, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses and hearing aids.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient & outpatient medical & surgical services & supplies, physical & speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible* plus 20% approved amount (plus any charge above approved amount).**
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Full cost of services.	Nothing for services.
HOME HEALTH CARE	Medically necessary skilled care, home health aide services, supplies, etc.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	Subject to deductible plus 20% of approved amount.
BLOOD	Blood	80% of approved amount (after $100 deductible and starting with 4th pint)	For first 3 pints plus 20% of approved amount for additional pints (after $100 deductible).***

* Once you have had $100 of expense for covered services in 1991, the Part B deductible does not apply to any further covered services you receive for the rest of the year.
** You pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as full payment for services rendered.
***To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

New in 1991

- Breast cancer screening (mammography)–Medicare medical insurance now helps pay for X-ray screenings to detect breast cancer. Women 65 or older can use the benefit every other year. Younger disabled women covered by Medicare can use it more frequently. Medicare will pay 80 percent of up to $55 for each screening.

- Physician payment reforms—In 1991, physicians who do not accept assignment (see page 8) may not charge you for office and hospital visits more than 140 percent of the Medicare prevailing charge for non-participating physicians. For most other services (surgery, for example) the limit is 125 percent. Physicians who knowingly charge more than these amounts are subject to sanctions. If you think you have been charged more than the acceptable level, contact your carrier.

You no longer have to file claims to Medicare for covered Part B services received after September 1, 1990. Doctors, suppliers and other providers of services must submit those claims for you. If your doctor or supplier refuses to submit or delays submission of a Part B Medicare claim for services furnished on or after September 1, 1990, and you believe those services may be covered by Medicare, notify your Medicare carrier. The name, address and telephone number of your carrier appear in the Medicare Handbook.

Medigap Insurance

Medicare provides basic protection against health care costs, but it does not pay all of your medical expenses, nor most long-term care expenses. If you wish to buy private health insurance to supplement Medicare (Medigap insurance), shop carefully. You can get a booklet, *Guide to Health Insurance for People with Medicare*, to help you make Medicare supplement decisions. The guide explains how supplemental insurance works and how to shop for it. (See instructions on page 10 for ordering publications.)

State and federal laws protect you against misleading sales practices regarding Medigap policies. An insurance company or agent may not knowingly sell you a policy that substantially duplicates coverage you already have, unless the policy pays duplicate benefits. Stricter nonduplication laws are scheduled to go into effect in November 1991. Penalties also apply if insurance agents tell you they are employees or agents of Medicare or any government agency.

Special Notice About Participating Physicians

Many doctors and suppliers have agreed to be part of Medicare's *participating physician and supplier program.* They "accept assignment" on all Medicare claims, which means they agree to accept the amount approved by Medicare as the total charge for covered services and supplies for all Medicare beneficiaries. If you receive services from a participating physician or supplier, you will be responsible only for paying your Medicare deductible and coinsurance amount (the 20 percent of the charge that Medicare does not pay for covered services). Getting services from participating doctors or suppliers can often save you money. Medicare-participating doctors and suppliers are listed by geographic area in the *Medicare-Participating Physician/Supplier Directory.* You can get a free copy from your Medicare carrier . Or you can call your carrier and ask for names of some participating doctors in your area. The directory is also available for review in Social Security offices, State and area offices of the Administration on Aging, and in most hospitals.

Help for Low-Income Beneficiaries

If you meet certain income and resource tests, your State's medical assistance program (Medicaid) may pay your share of health care costs under Medicare. To qualify, your annual income level must be near the national poverty guidelines (in 1991, $6,620 for one person, $8,880 for a family of two). Also, you cannot have resources such as bank accounts, stocks or bonds worth more than $4,000 ($6,000 for a couple). State governments assist qualified Medicare beneficiaries by paying the monthly Medicare premiums and, in most cases, paying Medicare deductibles and coinsurance. If you think you may qualify, contact your state or local welfare, social services or public health agency and ask about the Qualified Medicare Beneficiary program.

Reporting Fraud and Abuse in Medicare

If you believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services you did not receive, you should immediately report this to the Medicare contractor that handles your claims. The number of your Medicare contractor is listed on the notice explaining Medicare's decision on your Medicare claim.

If the Medicare contractor does not respond adequately to your report of Medicare fraud or abuse, you should call the U.S. Department of Health and Human Services, Office of Inspector General toll-free Hotline (1-800-368-5779). Be prepared to tell the operator:

- The exact nature of the wrongdoing you suspect, the date it occurred, and the name and address of the party involved.
- The name and location of the Medicare contractor you reported it to, and when you reported it.
- The name of any contractor employee to whom you spoke, and what advice that person gave you.

You may also report to the Office of Inspector General by writing to: OIG Hotline, P.O. Box 17303, Baltimore, Maryland, 21203-7303.

Call or write your Medicare contractor first for faster action. Do not call the Inspector General Hotline for Medicare policy questions or questions about delayed claims or payments.

Coordinated Care

Medicare beneficiaries may have lower out-of-pocket costs if they choose to enroll in prepaid health care plans that participate in Medicare, instead of receiving services through traditional fee-for-service arrangements. Approximately 75 percent of Medicare beneficiaries live in areas served by prepaid plans. Medicare enters prepayment contracts with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide coordinated care to Medicare beneficiaries. Medicare pays the plans a fixed amount each month to provide Medicare enrollees with all Medicare-approved services. Some plans offer services beyond those covered by Medicare, such as certain preventive services.

Publications Available About Medicare

Single copies of the publications listed below are available from regional offices of the Health Care Financing Administration, and the Federal Consumer Information Center, Department 59, Pueblo, CO 81009. Please allow several weeks for delivery. For bulk orders contact the Office of Public Affairs, Health Care Financing Administration, 200 Independence Avenue, SW, Washington, DC, 20201. Free publications:

*1991 Medicare Handbook (HCFA 10050)**
Guide to Health Insurance for People with Medicare(HCFA 02110)
Hospice Benefits Under Medicare (HCFA 02154)
Medicare and Coordinated Care Plans (HCFA 02143)
Getting a Second Opinion (HCFA 02114)
Medicare and Employer Health Plans (HCFA 02150)
Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (HCFA 10128)

* Not available from Pueblo

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